Federal Fiscal Year 2001
FRAMEWORK FOR ANNUAL REPORT
OF STATE CHILDREN'S HEALTH INSURANCE PLANS
UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

Preamble
Section 2108(a) of the Act provides that the State must assess the operation of the State child health plan in each fiscal year, and report to the Secretary, by January 1 following the end of the fiscal year, on the results of the assessment. In addition, this section of the Act provides that the State must assess the progress made in reducing the number of uncovered, low-income children.

To assist states in complying with the statute, the National Academy for State Health Policy (NASHP), with funding from the David and Lucile Packard Foundation, has coordinated an effort with states to develop a framework for the Title XXI annual reports.

The framework is designed to:

- Recognize the ***diversity*** of State approaches to SCHIP and allow States ***flexibility*** to highlight key accomplishments and progress of their SCHIP programs, **AND**
- Provide ***consistency*** across States in the structure, content, and format of the report, **AND**

- Build on data ***already collected*** by CMS quarterly enrollment and expenditure reports, **AND**

- Enhance ***accessibility*** of information to stakeholders on the achievements under Title XXI.

Federal Fiscal Year 2001
FRAMEWORK FOR ANNUAL REPORT
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UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

State/Territory: Oregon
(Name of State/Territory)

The following Annual Report is submitted in compliance with Title XXI of the Social Security Act (Section 2108(a)).

(Signature of Agency Head)

SCHIP Program Name(s) Oregon Children's Health Insurance Program

SCHIP Program Type:
____Medicaid SCHIP Expansion Only
__X_Separate SCHIP Program Only
_____Combination of the above

Reporting Period: Federal Fiscal Year 2001 (10/1/2000-9/30/2001)

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Submission Date: January 15, 2002

(Due to your CMS Regional Contact and Central Office Project Officer by January 1, 2002)
Please cc Cynthia Pernice at NASHP (cpernice@nashp.org)

SECTION 1. DESCRIPTION OF PROGRAM CHANGES AND PROGRESS

This sections has been designed to allow you to report on your SCHIP program changes and progress during Federal fiscal year 2001 (September 30, 2000 to October 1, 2001).

1.1 Please explain changes your State has made in your SCHIP program since September 30, 2000 in the following areas and explain the reason(s) the changes were implemented.

Note: If no new policies or procedures have been implemented since September 30, 2000, please enter "NC" for no change. If you explored the possibility of changing/implementing a new or different policy or procedure but did not, please explain the reason(s) for that decision as well.

A.	Program eligibility	N/C
B.	Enrollment process	N/C
C.	Presumptive eligibility	N/C
D.	Continuous eligibility	N/C
E.	Outreach/marketing campaigns	N/C
F.	Eligibility determination process	N/C
G.	Eligibility redetermination process	N/C
H.	Benefit structure	N/C
I.	Cost-sharing policies	N/C
J.	Crowd-out policies	N/C
K.	Delivery system	N/C
L.	Coordination with other programs (especially private insurance and Medicaid)	N/C
M.		
N.	Screen and enroll process	N/C
O.	Application	N/C
P.	Other	N/C

1.2 Please report how much progress has been made during FFY 2001 in reducing the number of uncovered low-income children.

A. Please report the changes that have occurred to the number or rate of uninsured, low-income children in your State during FFY 2001. Describe the data source and method used to derive this information.

Because of the increase in the number of low-income children covered through SCHIP and Medicaid (Table 1.3 B) , it is expected that the number of uninsured, low income children in Oregon has been reduced in FFY 2001. Combined enrollment in Medicaid and SCHIP increased by 17,719 (9.3%) in FFY 2001.

Prior to the implementation of SCHIP, it was estimated that the number of income eligible, uninsured children in 1998 was approximately 22,600. Since the implementation of Oregon SCHIP in July 1998, more than 71,000 unduplicated children have been enrolled in the program at any one time. Currently, 86.6% of the estimated SCHIP eligible children are enrolled in SCHIP (Table 1.3 A).

B. How many children have been enrolled in Medicaid as a result of SCHIP outreach activities and enrollment simplification? Describe the data source and method used to derive this information.

Outreach activities for both programs are combined and conducted by 140 outreach facilities located throughout the state. Activities are not tracked separately for each program.

C. Please present any other evidence of progress toward reducing the number of uninsured, low-income children in your State.

See A above

D. Has your State changed its baseline of uncovered, low-income children from the number reported in your March 2000 Evaluation?

X No, skip to 1.3

____ Yes, what is the new baseline?

What are the data source(s) and methodology used to make this estimate?

What was the justification for adopting a different methodology?

What is the State's assessment of the reliability of the estimate? What are the limitations of the data or estimation methodology? (Please provide a numerical range or confidence intervals if available.)

Had your state not changed its baseline, how much progress would have been made in reducing the number of low-income, uninsured children?

1.3 Complete Table 1.3 to show what progress has been made during FFY 2001 toward achieving your State's strategic objectives and performance goals (as specified in your State Plan).

In Table 1.3, summarize your State's strategic objectives, performance goals, performance measures and progress towards meeting goals, as specified in your SCHIP State Plan. Be as specific and detailed as possible. Use additional pages as necessary. The table should be completed as follows:

Column 1:	List your State's strategic objectives for your SCHIP program, as specified in your State Plan.
Column 2:	List the performance goals for each strategic objective.
Column 3:	For each performance goal, indicate how performance is being measured, and progress towards meeting the goal. Specify data sources, methodology, and specific measurement approaches (e.g., numerator and denominator). Please attach additional narrative if necessary.

Note: *If no new data are available or no new studies have been conducted since what was reported in the March 2000 Evaluation, please complete columns 1 and 2 and enter "NC" (for no change) in column 3*.

Table 1.3 (1) Strategic Objectives (as specified in Title XXI State Plan and listed in Your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
Objectives related to Reducing the Number of Uninsured Children		
Objective 1 **Expand OHP eligibility rules to include uninsured children living in households with incomes that fall within:** 100-170% FPL children 6 through 18 years 133-170% FPL children birth through age 18.	**Performance Goal for Objective 1** By July 1, 1998 the Office of Medical Assistance Programs (OMAP) will expand the capacity of the OHP to meet the needs of 17,000 CHIP eligibles. OMAP's data and operational systems will be structured to accommodate CHIP criteria in the areas of eligibility determination, enrollment, client information and utilization of health care services. OMAP staff and Department of Human Services (DHS) field personnel will receive CHIP related training.	N/C
Objectives Related to SCHIP Enrollment		
Objective 2 Identify CHIP eligibles through coordinated and ongoing outreach activities.	**Performance Goal for Objective 2** By January 1, 1999 OMAP will develop and implement outreach efforts among current Medicaid OHP channels to identify, enroll and meet the health care needs of the CHIP population.	Data Sources: n/a Methodology: n/a Numerator: n/a Denominator: n/a Progress Summary: Goal met. The number of outreach facilities has increased to 140 from 130 reported in 2000.

Table 1.3 (1) Strategic Objectives (as specified in Title XXI State Plan and listed in Your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)

Objectives Related to Increasing Medicaid Enrollment		
Objective 3 Enroll SCHIP eligibles in the OHP health care delivery system to assure a usual source of health care coverage.	**Performance Goal for Objective 3:** By July 1, 1999, 17,000 low income children will be enrolled in Oregon SCHIP. They will have access to a usual source of health care coverage in the form of a stable health care plan and an assigned primary care provider.	**Data Sources:** Medicaid/SCHIP MMIS data **Methodology:** The number of children enrolled on September 30, 2000. **Progress Summary:** . As of September 30, 2001 17,465 children were enrolled in SCHIP. The program has been expanded to cover 19,800 children. The initial enrollment goal was not met by the date specified due to higher than predicted disenrollment rates following the end of the 6-month eligibility period.
Objectives Related to Increasing Access to Care (Usual Source of Care, Unmet Need)		
Objective 4 Monitor access and utilization patterns among CHIP enrollees.	**Performance Goal for Objective 4:** By July 1, 1998, CHIP enrollees will be assigned a unique code that will enable OMAP analysts to distinguish CHIP clients from the OHP Medicaid population. OMAP will monitor CHIP utilization patterns to help assure access to health care and the delivery of medically appropriate care.	**Data Sources**: Medicaid/SCHIP MMIS data **Methodology:** HEDIS® 2000 **Progress Summary**: Goal met. See Tables 1.3 A-F. Unique SCHIP codes are assigned to children when they enroll in SCHIP. OHP enrollment history (SCHIP and Medicaid); Managed Care Organization (MCO) enrollment; as well as claims and encounter data is collected. This information allows OMAP to track children's enrollment in SCHIP and Medicaid and their use of services.

Objectives Related to Use of Preventative Care (Immunizations, Well Child Care)		
Objective 5. Improve the health status of CHIP enrollees through provider and client programs specific to the needs of this population.	**Performance Goal for Objective 5** By July 1, 1999, the following health status and health care system measures for Oregon's CHIP enrollees will be collected and analyzed to demonstrate acceptable incremental improvement in the following areas: childhood and adolescent immunization status, well child and adolescent well care visits, early childhood caries prevention and client satisfaction with access to, choice of and quality of health care.	**Data Sources**: Medicaid/CHIP enrollment data, Encounter Data, Claims MMIS data **Methodology:** HEDIS® 2000 **Progress Summary:** Children enrolled in Oregon SCHIP have access to a comprehensive array of medical, dental, chemical dependency and mental health services as part of the Oregon Health Plan delivery system. Well-child and primary care visits are reported in Tables 1.3 C-F following a modified HEDIS® methodology for continuously enrolled SCHIP children. The data show that 84% of children enrolled in SCHIP received at least one primary care visit during the calendar year 2000. Over 95% of infants received at least 1 well-child visit. Due to the difficulty of reporting early childhood cavities prevention, treating children's ear infections and adolescent immunization rates, Oregon's State Plan was amended to waive these measures.
Other Objectives		
		Data Sources: Methodology: Progress Summary:

TABLE 1.3 A
PERCENTAGE OF SCHIP ELIGIBLE CHILDREN ENROLLED IN SCHIP

	EST SCHIP ELIG 1998	SCHIP ENROLLED SEP-30-01	% SCHIP ENROLLED SEP-01
TOTAL	22,662	19,632	86.6%

TABLE 1.3 B
OREGON HEALTH PLAN ENROLLMENT

Program	FFY 97	FFY 98	FFY 99	FFY 00	FFY 01
Medicaid	168,442	166,959	169,012	171,679	187,785
SCHIP	0	6,250	15,173	18,019	19,632
FHIAP*	0	N/A	2,066	1,285	1,490
Total	168,442	173,209	186,251	190,983	208,907

*Family Health Insurance Assistance Program,
a non OMAP program,
operated by the Dept of Consumer & Business Services

TABLE 1.3 C
WELL-INFANT VISIT 15 MONTHS
Rates calculated from encounter data

NUMBER OF VISITS	DENOM	NUM	%
0	212	10	4.7%
1	212	18	8.5%
2	212	23	10.8%
3	212	30	14.2%
4	212	33	15.6%
5	212	43	20.3%
6 OR MORE	212	55	25.9%

TABLE 1.3 D
WELL CHILD VISITS

AGE BRACKET	DENOM	NUM	%
3 - 6 YRS	1092	387	35.4%
ADOLESCENT	2026	391	19.3%

Rates calculated from encounter data

TABLE 1.3 E
PRIMARY CARE VISITS

AGE BRACKET	DENOM	NUM	%
12-24 mos	189	185	97.9%
25 mos – 6 yrs	1331	1098	82.5%
7 – 11 yrs	1877	1578	84.1%
TOTAL	**3397**	**2861**	**84.2%**

Rates calculated from encounter data

TABLE 1.3 F
CHILDHOOD IMMUNIZATION RATES

	DENOM	NUM	%
4:3:1*	813	585	72.0%
TOTAL	**813**	**585**	**72.0%**

*Used NIS criteria. 4 DTP, 3 Polio, 1 MMR
19-35 months of age
Rates calculated using state immunization registry data

1.4 If any performance goals have not been met, indicate the barriers or constraints to meeting them.

N/A

1.5 Discuss your State's progress in addressing any specific issues that your state agreed to assess in your State plan that are not included as strategic objectives.

Additional measures in the original state plan include: treating children's ear infections, early childhood caries prevention and satisfaction to access to, choice of and quality of health care have proven more difficult to measure, due to the small size and fluidity of enrollment patterns in the SCHIP program and difficulty in developing an appropriate measure.

1.6 Discuss future performance measurement activities, including a projection of when additional data are likely to be available.

Childhood immunization rates will be available by February 2002.

1.7 Please attach any studies, analyses or other documents addressing outreach, enrollment, access, quality, utilization, costs, satisfaction, or other aspects of your SCHIP program's performance. Please list attachments here.

Oregon's SCHIP program is integrated seamlessly with Oregon's 1115 Medicaid waiver program and is part of a well established continuous quality improvement (CQI) program.

Components of this CQI program specific to children's health include:

- On-Site Quality Improvement Evaluations. The focus of the current cycle includes prevention, member education and community partnerships. Areas of review include well-child visits, services to children with special health care needs and early childhood cavities prevention and Exceptional Needs Care Coordination.
- Children enrolled in SCHIP are included in External Quality Review studies.
- Health Plan Performance Measures. MCOs are required to annually report Childhood Immunization rates.
- Member Surveys. Through the use of the Consumer Assessment of Health Plan Survey (CAHPS), OHP adults and children (parents) are surveyed to gauge satisfaction with and access to health services (both MCO and fee-for-service) received under OHP.
- Project: PREVENTION! is a management and quality initiative undertaken on behalf of OHP members to increase utilization of proven preventive services. Statewide initiatives include: development of an immunization registry, tobacco cessation and early childhood cavities prevention.
- Health Care Performance Measures. In addition to the performance measures submitted by health plans, OMAP collects health care performance measures to compare and monitor individual MCO, and PCCM performance.

SECTION 2. AREAS OF SPECIAL INTEREST

This section has been designed to allow you to address topics of current interest to stakeholders, including; states, federal officials, and child advocates.

2.1 Family coverage: Not applicable

A. If your State offers family coverage, please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other program(s). Include in the narrative information about eligibility, enrollment and redetermination, cost sharing and crowd-out.

B. How many children and adults were ever enrolled in your SCHIP family coverage program during FFY 2001 (10/1/00 - 9/30/01)?

_____Number of adults
_____Number of children

C. How do you monitor cost-effectiveness of family coverage?

2.2 Employer-sponsored insurance buy-in: Not Applicable

A. If your State has a buy-in program, please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other SCHIP program(s).

B. How many children and adults were ever enrolled in your SCHIP ESI buy-in program during FFY 2001?

_____Number of adults
_____Number of children

2.3 Crowd-out:

A. How do you define crowd-out in your SCHIP program?

Oregon defines crowd-out as the substitution of public health care coverage for private coverage. To avoid this substitution, Oregon requires a 6-month uninsurance period. Children with life threatening or disabling health conditions are exempted from this requirement.

B. How do you monitor and measure whether crowd-out is occurring?

The identification of children who are currently covered under private health insurance is addressed in the application and eligibility determination process. Applicants are required to report private health insurance coverage.

C. What have been the results of your analyses? Please summarize and attach any available reports or other documentation.

D. Which anti-crowd-out policies have been most effective in discouraging the substitution of public coverage for private coverage in your SCHIP program? Describe the data source and method used to derive this information.

Oregon relies on the 6-month waiting period to prevent crowd out.

2.4 Outreach:

A. What activities have you found most effective in reaching low-income, uninsured children? How have you measured effectiveness?

Oregon produces an informational brochure that is available to schools, Doctor's offices, or any entity serving low-income or uninsured children and their parents. This brochure, which is available in eleven languages, gives the clients phone numbers to call for applications and explains basic eligibility requirements. The effectiveness has not been measured, except in terms of increased demand for the brochure primarily from elementary schools.

B. Have any of the outreach activities been more successful in reaching certain populations (e.g., minorities, immigrants, and children living in rural areas)? How have you measured effectiveness?

Through a Covering Kids grant from the Robert Wood Johnson Foundation, four areas of the state have been targeted. These include two densely populated Hispanic areas, one rural area and one urban area serving homeless children. The assessment of this grant and its results are addressed by the Oregon Health Division.

C. Which methods best reached which populations? How have you measured effectiveness?

The most effective method we have to reach all populations is through our statewide network of outreach facilities. These 140 facilities, in addition to the statewide field office structure of the Adult and Family Services, make access to the Oregon Health Plan very easy. The methods used to assist clients range from distribution of applications to assisting the clients with each step in completing their application.

2.5 Retention:

A. What steps are your State taking to ensure that eligible children stay enrolled in Medicaid and SCHIP?

To facilitate continuous health care coverage for eligible children, the OHP application processing center sends a notice and a new application to enrollees notifying them that their coverage is scheduled to end soon. Enrollees receive a total of three notices before coverage is terminated.

B. What special measures are being taken to reenroll children in SCHIP who disenroll, but are still eligible?

___ Follow-up by caseworkers/outreach workers
__X_ Renewal reminder notices to all families
___ Targeted mailing to selected populations, specify population
___ Information campaigns
___ Simplification of re-enrollment process, please describe
___Surveys or focus groups with disenrollees to learn more about reasons for disenrollment, please describe
___ Other, please explain

C. Are the same measures being used in Medicaid as well? If not, please describe the differences.

Yes, the same measures are being used for Medicaid.

D. Which measures have you found to be most effective at ensuring that eligible children stay enrolled?

Renewal reminder notices.

E. What do you know about insurance coverage of those who disenroll or do not reenroll in SCHIP (e.g., how many obtain other public or private coverage, how many remain uninsured?) Describe the data source and method used to derive this information.

Research conducted by the Center for Health Economics Research on children covered by Oregon Medicaid and SCHIP showed that 45% of children whose SCHIP coverage ended transitioned directly into Medicaid. This data was collected from MMIS eligibility files. Further research is being conducted by HER to determine the insurance status of the children who were no longer covered by SCHIP or Medicaid.

2.6 Coordination between SCHIP and Medicaid:

A. Do you use common application and redetermination procedures (e.g., the same verification and interview requirements) for Medicaid and SCHIP? Please explain.

Yes, the same application and eligibility determination process is used for both Medicaid and SCHIP.

B. Explain how children are transferred between Medicaid and SCHIP when a child's eligibility status changes.

Eligibility is redetermined at the time of re-application for OHP coverage. An eligibility worker screens the application to determine if the child is eligible for coverage under Medicaid**.** If the child is ineligible for Medicaid they are then screened for SCHIP eligibility.

C. Are the same delivery systems (including provider networks) used in Medicaid and SCHIP? Please explain.

Yes, Oregon contracts with 16 fully capitated health plans, 7 dental plans and one separate chemical dependency organization to provide comprehensive medical, dental, chemical dependency coverage to children throughout the state which covers approximately 70% of OHP clients throughout the state. In areas where managed care plans are not available, clients receive services through fee-for-service (FFS) or primary care case management (PCCM) providers. Mental health services are provided through Mental Health Organizations and are tracked by the Mental Health Division.

2.7 Cost Sharing: Not applicable

A. Has your State undertaken any assessment of the effects of premiums/enrollment fees on participation in SCHIP? If so, what have you found?

B. Has your State undertaken any assessment of the effects of cost-sharing on utilization of health service under SCHIP? If so, what have you found?

2.8 Assessment and Monitoring of Quality of Care:

A. What information is currently available on the quality of care received by SCHIP enrollees? Please summarize results.

See Tables 1.3 C-F

B. What processes are you using to monitor and assess quality of care received by SCHIP enrollees, particularly with respect to well-baby care, well-child care, immunizations, mental health, substance abuse counseling and treatment and dental and vision care?

See Tables 1.3 C-F and response to question 1.7.

C. What plans does your SCHIP program have for future monitoring/assessment of quality of care received by SCHIP enrollees? When will data be available?

See response to question 1.6.

SECTION 3. SUCCESSES AND BARRIERS

This section has been designed to allow you to report on successes in program design, planning, and implementation of your State plan, to identify barriers to program development and implementation, and to describe your approach to overcoming these barriers.

3.1 Please highlight successes and barriers you encountered during FFY 2001 in the following areas. Please report the approaches used to overcome barriers. Be as detailed and specific as possible.

Note: If there is nothing to highlight as a success or barrier, Please enter "NA" for not applicable.

A. Eligibility

As reported in Section 1, the Oregon SCHIP program was expanded to cover 19,800 children (up from 16,800 children). This has allowed our program to remain open to new enrollment for an additional period of time.

B. Outreach

Effective outreach continues through the use of outreach facilities as described in Section 2.4

C. Enrollment

The total number of unduplicated children ever covered by SCHIP in Oregon is more than 71,000 since July 1, 1998, which exceeded our expectations for the program.

D. Retention/disenrollment

High disenrollment rates after the 6-month continuous eligibility continued through FFY 2001. However, the higher disenrollment rates have allowed the Oregon SCHIP program to remain open to new enrollees longer than anticipated.

E. Benefit structure

Oregon provides children enrolled in SCHIP with a comprehensive array of medical, dental, chemical dependency and mental health benefits, mirroring the benefits offered in our Medicaid program.

F. Cost-sharing

There is no cost sharing under the Oregon SCHIP program.

G. Delivery system

Much of Oregon's success with SCHIP is due to the "seamlessness" with Medicaid. Because Oregon SCHIP is a Medicaid "lookalike" the delivery system of managed care organizations is seamless between Medicaid and SCHIP. This has allowed a high degree of continuity for children covered under SCHIP.

H. Coordination with other programs

Because the same application and eligibility determination processed is used for SCHIP and Medicaid, the coordination between the two programs has operated seamlessly.

I. Crowd-out

OMAP uses a 6-month waiting period to prevent crowd-out. This appears to be an adequate measure to discourage substitution of health insurance coverage.

J. Other

SECTION 4: PROGRAM FINANCING

This section has been designed to collect program costs and anticipated expenditures.

4.1 **Please complete Table 4.1 to provide your budget for FFY 2001, your current fiscal year budget, and FFY 2002-projected budget. Please describe in narrative any details of your planned use of funds.**

N*ote: Federal Fiscal Year 2000 starts 10/1/99 and ends 9/30/00).*

CHIP BUDGET PLAN

	Federal Fiscal Year 2000 Costs	Federal Fiscal Year 2001	Federal Fiscal Year 2002
Benefit Costs			
Insurance Payments			
Managed Care	12,098,472	13,165,600	15,188,600
per member/per month rate			
x # of eligibles			
Fee For Service	5,068,415	5,642,400	6,509,400
Total Benefit Costs	17,166,887	18,808,000	21,698,000
(Offsetting benficiary cost sharing payments)			
Net Benefit Costs	17,166,887	18,808,000	21,698,000
Administration Costs			
Personnel	214,342	247,000	286,000
General Administration			
Contractors/Brokers (e.g. enrollment contractors)			
Claims Processing			
Outreach/Marketing Costs			
Other			
Total Administration Costs	214,342	247,000	286,000
10% Administative Cost Ceiling	1,716,689	1,880,800	2,169,800
Federal Share (Multiplied by	12,509,268	13,586,000	15,577,000

CHIP BUDGET PLAN

	Federal Fiscal Year 2000 Costs	Federal Fiscal Year 2001	Federal Fiscal Year 2002
Enhanced FMAP Rate) State Share	4,871,960	5,469,000	6,407,000
TOTAL PROGRAM COSTS	17,381,229	19,055,000	21,984,000

4.2 Please identify the total State expenditures for family coverage during Federal fiscal year 2001. N/A

4.3 What were the non-Federal sources of funds spent on your SCHIP program during FFY 2001?

___X State appropriations
_____County/local funds
_____Employer contributions
_____Foundation grants
_____Private donations (such as United Way, sponsorship)
_____Other (specify)

A. Do you anticipate any changes in the sources of the non-Federal share of plan expenditures.

No

SECTION 5: SCHIP PROGRAM AT-A-GLANCE

This section has been designed to give the reader of your annual report some context and a quick glimpse of your SCHIP program.

5.1 To provide a summary at-a-glance of your SCHIP program characteristics, please provide the following information. If you do not have a particular policy in-place and would like to comment why, please do. (Please report on initial application process/rules)

Table 5.1	**Medicaid Expansion SCHIP program**	**Separate SCHIP program**
Program Name	NOT APPLICABLE	Oregon Separate S-CHIP Program
Provides presumptive eligibility for children	_____No _____Yes, for whom and how long?	___XNo _____Yes, for whom and how long?
Provides retroactive eligibility	_____No _____Yes, for whom and how long?	__X__No _____Yes, for whom and how long?
Makes eligibility determination	_____State Medicaid eligibility staff _____Contractor _____Community-based organizations _____Insurance agents _____MCO staff _____Other *(specify)*	____X State Medicaid eligibility staff _____Contractor _____Community-based organizations _____Insurance agents _____MCO staff ____Other *(specify)*
Average length of stay on program	Specify months	Specify months __6-7 months
Has joint application for Medicaid and SCHIP	_____No _____Yes	_____No ___X Yes
Has a mail-in application	_____No _____Yes	_____No ____Xyes

Can apply for program over phone	_____No _____Yes	___X_No _____Yes
Can apply for program over internet	_____No _____Yes	___X No _____Yes
Requires face-to-face interview during initial application	_____No _____Yes	____XNo _____Yes
Requires child to be uninsured for a minimum amount of time prior to enrollment	_____No _____Yes, specify number of months What exemptions do you provide?	_____No ___X Yes, specify number of months ___6 What exemptions do you provide? *Life threatening or disabling conditions*
Provides period of continuous coverage <u>regardless of income changes</u>	_____No _____ Yes, specify number of months Explain circumstances when a child would lose eligibility during the time period	_____No __X__Yes, specify number of months 6_____ Explain circumstances when a child would lose eligibility during the time period
Imposes premiums or enrollment fees	**_____No** **_____Yes, how much?** **Who Can Pay?** ___ **Employer** ___ **Family** ___ **Absent parent** ___ **Private donations/** sponsorship ___ Other (specify)	__X__No _____Yes, how much? Who Can Pay? ___ Employer ___ Family ___ Absent parent ___ Private donations/sponsorship ___ Other (specify)
Imposes copayments or coinsurance	_____No _____Yes	___X_No _____Yes
Provides	_____ No	___X_ No

preprinted redetermi-nation process	_____ Yes, we send out form to family with their information precompleted and: ___ ask for a signed confirmation that information is still correct ___ do not request response unless income or other circumstances have changed	_____ Yes, we send out form to family with their information and: ___ ask for a signed confirmation that information is still correct ___ do not request response unless income or other circumstances have changed

5.2 Please explain how the redetermination process differs from the initial application process.

The Oregon Health Plan uses the same application process for eligibility redetermination.

SECTION 6: INCOME ELIGIBILITY

This section is designed to capture income eligibility information for your SCHIP program.

6.1 As of September 30, 2001, what was the income standard or threshold, as a percentage of the Federal poverty level, for countable income for each group? If the threshold varies by the child's age (or date of birth), then report each threshold for each age group separately. Please report the threshold after application of income disregards.

Title XIX Child Poverty-related Groups or Section 1931-whichever category is higher

0-170% of FPL for children under age <1 yr
0-133% of FPL for children aged 1-5 years

Medicaid SCHIP Expansion N/A

____% of FPL for children aged _____
____% of FPL for children aged _____
____% of FPL for children aged _____

Separate SCHIP Program

134 to 170% of FPL for children aged 1 - 5 years
101 to 170% of FPL for children aged 6 - 18 years

6.2 As of September 30, 2001, what types and *amounts* of disregards and deductions does each program use to arrive at total countable income? *Please indicate the amount of disregard or deduction used when determining eligibility for each program. If not applicable, enter "NA".*

Do rules differ for applicants and recipients (or between initial enrollment and redetermination)

____ Yes __X__ No

If yes, please report rules for applicants (initial enrollment).

Table 6.2			
	Title XIX Child Poverty-related Groups	Medicaid SCHIP Expansion	Separate SCHIP Program
Earnings	$0	N/A	$0
Self-employment	$0	$	$0
Alimony payments Received	$0	$	$0
Paid	$0		$0
Child support payments Received	$0	$	$0
Paid	$0	$	$0
Child care expenses	$0	$	$0
Medical care expenses	$0	$	$0
Gifts	$0	$	$0
Other types of disregards/deductions (specify)	$0	$	$0

6.3 For each program, do you use an asset test? YES

Title XIX Poverty-related Groups

___No X Yes, specify countable or allowable level of asset test: $2000

Medicaid SCHIP Expansion program N/A

____No____Yes, specify countable or allowable level of asset test_____

Separate SCHIP program

____No X Yes, specify countable or allowable level of asset test $5000

Other SCHIP program_____

____No____Yes, specify countable or allowable level of asset test_____

6.4 Have any of the eligibility rules changed since September 30, 2001?

___ Yes X No

SECTION 7: FUTURE PROGRAM CHANGES

This section has been designed to allow you to share recent or anticipated changes in your SCHIP program.

7.1 What changes have you made or are planning to make in your SCHIP program during FFY 2001(10/1/00 through 9/30/01)? Please comment on why the changes are planned.

A. Family coverage. N/C

B. Employer sponsored insurance buy-in. N/C

C. 1115 waiver. N/C

D. Eligibility including presumptive and continuous eligibility. N/C

E. Outreach. N/C

F. Enrollment/redetermination process. N/C

G. Contracting. N/C

H. Other
In 2001, the State of Oregon, passed a bill to implement the Oregon Health Plan 2 (OHP2). This would be a two tiered state plan which would expand health coverage to adults and children to 185% of the FPL. A "leaner" benefits package with cost sharing provisions would be offered to non-categorical eligible adults, while children, pregnant women and categorical eligibles would remain in a program similar to the existing OHP. The implementation date is scheduled for October 2002. The plan for this program is currently in development and has not yet been submitted to CMS.